

History of Present Illness

Chief Complaint (Describe symptoms and problems): _____

Pain location: _____

Onset was (gradual, abrupt, etc.): _____

Symptoms began: _____

Symptoms occur (after meals, at night, after drinking, etc.): _____

Pain lasts (2 hours, constant, etc.): _____

Pain is (sharp, dull, burning, etc.): _____

Last bowel movement: _____

Current treatment to relieve symptoms: _____

PATIENT HEALTH HISTORY

Date: _____

Name _____
First Middle Last

Gender: Male Female Age: _____

Date Of Birth: _____

Prescription Medications			
None		Dose	Frequency
Coumadin? Yes No <i>Why taking?</i>			

Over-the-Counter Medications			
None		Dose	Frequency
Aspirin? Yes No <i>Why taking?</i>			
Advil, Arthritis Meds? Yes No			

Vitamins/Herbals			
None		Dose	Frequency
Iron? Yes No			

Medication Allergies	
None	Circle Reaction
	Shortness of breath, hives, rash, itching, other _____
	Shortness of breath, hives, rash, itching, other _____
	Shortness of breath, hives, rash, itching, other _____

Family Health History

<i>Health is:</i>	<i>Good</i>	<i>Poor</i>	<i>Deceased-Cause of Death</i>	<i>Age</i>
Father				
Mother				
Brother				
Sister				

Immediate Family History of Disease

<i>History of: (Circle answer)</i>	<i>Relationship (father, sister, etc.)</i>
<i>Colon Cancer?</i> Yes No	
<i>Crohn's Disease?</i> Yes No	
<i>Diabetes?</i> Yes No	
<i>Liver Disease?</i> Yes No	
<i>Pancreatitis?</i> Yes No	
<i>Sprue?</i> Yes No	
<i>Ulcers?</i> Yes No	
<i>Ulcerative Colitis?</i> Yes No	

Please complete the reverse side of this form. ⇨
Thank You.

Review of Systems (✓ if you have any of the following)

Gastrointestinal:

- No Symptoms*
- Abdominal Pain
- Bloating
- Change in Bowel Habits
- Constipation
- Decreased appetite
- Diarrhea
- Diverticulosis/Diverticulitis
- Gas
- Gallbladder Disease
- Gallbladder Stones
- Heartburn
- Hemorrhoids
- Hiatal Hernia
- Indigestion
- Inflammatory Bowel Disease
- Jaundice/Hepatitis
- Nausea/Vomiting
- Pancreatitis
- Previous Colon Polyp/Tumor
- Rectal Bleeding
- Trouble Swallowing
- Ulcer

Respiratory:

- No Symptoms*
- Asthma or emphysema
- Chronic cough
- Coughing up blood
- History -pulmonary embolism
- Oxygen therapy
- Pneumonia
- Shortness of breath
- Tuberculosis

Cardiovascular:

- No Symptoms*
- Chest pain
- Heart attack
- Heart murmur
- High blood pressure
- Irregular/rapid heart beat
- Low blood pressure
- Pacemaker/Defibrillator
- Rheumatic heart disease
- Swelling of ankles/feet
- Valve replacement
- Congestive heart failure

Genitourinary:

- No Symptoms*
- Blood in urine
- Frequent urination
- Lack of bladder control
- Kidney stones
- Kidney disease
- Renal failure/Dialysis
- Urinary infections

Neurologic:

- No Symptoms*
- Dizziness/Fainting spells
- Localized weakness

Neurologic - Cont.:

- Paralysis
- Recurrent headache
- Seizures/Epilepsy
- Stroke/TIA

Muscles/Joints/Bones:

- No Symptoms*
- Artificial Joints
- Arthritis
- Back or neck injury
- Gout
- Rheumatoid arthritis
- Swelling/pain in:
 - Arms Hips
 - Back Legs
 - Feet Neck
 - Hands Shoulders

Endocrine:

- No Symptoms*
- Cortisone therapy
- Diabetes
- Dry mouth
- Excessive hunger
- Excessive thirst
- Hormone therapy
- Parathyroid problem
- Thyroid problem/Goiter

Ear/Nose/Throat:

- No Symptoms*
- Bleeding gums
- Dentures
- Hay fever
- Hearing loss
- Hoarseness
- Nosebleeds
- Sinus problems
- Sores in mouth

Skin:

- No Symptoms*
- Hives-Rash
- Itching
- Sores that won't heal

Eyes:

- No Symptoms*
- Dry eyes
- Glaucoma
- Iritis
- Limited vision
- Yellow eyes

Lymphatic:

- No Symptoms*
- Abnormal bleeding
- Anticoagulation therapy
- Blood disorder/Anemia
- Bruise easily
- Phlebitis/Blood clots
- Swollen lymph nodes

Infectious Disease:

- No Symptoms*
- Hepatitis (A, B, C)
- Sexually transmitted disease

Mental Health:

- No Symptoms*
- Depression
- Panic Attacks/Anxiety
- Phobias

Constitutional:

- No Symptoms*
- Chills
- Fever
- Forgetfulness
- Loss of sleep
- Night sweats
- Recent weight loss
- Recent weight gain

Past Medical History

- Please mark the procedures you have had:
- Blood Transfusion
 - Colonoscopy
 - Flexible Sigmoidoscopy
 - EGD
 - ERCP
 - Mammogram

Surgeries & Hospitalizations

	Year
	Year
	Year
	Year
	Year
	Year

Social History (Mark your answers with a ✓)

Caffeine:

- I do NOT drink caffeine
- Coffee # cups/day
- Decaf # cups/day
- Tea # cups/day
- Cola # 8 oz glasses/day

Tobacco:

- I do NOT smoke
- I've NEVER smoked
- I smoke
 - # Cigarettes per day
 - # Cigars per day
 - a Pipe
 - I quit smoking in Yr

Alcohol:

- I NEVER drink alcohol
- I drink:
 - # Beers per day
 - # Shots per day
 - # Mixed drinks/day
 - # Glasses of wine/day
 - Other _____
- I am a binge drinker
- I am an alcoholic
- I am a reformed alcoholic
- I drink socially

Non-Prescription Drugs:

- I do NOT use drugs
- I use recreational drugs
- I use IV drugs

Marital Status:

- Married
- Single
- Separated
- Divorced
- Widowed

Living Arrangements:

- Live with spouse/family
- Live alone
- Live with friends
- Live with significant other
- Live in nursing home
- Live in Assisted Living Apt.

Children:

- Yes, How many? _____
- No

Occupation:

Do you have Advanced Medical Directives (Living Will)?

- Yes
- No

I certify that the above information is correct and to the best of my knowledge. I will not hold my physician or any member of their staff responsible for an errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Date _____